STATEMENT OF EMERGENCY

907 KAR 1:632E

(1) This emergency administrative regulation is being promulgated in conjunction with three (3) other emergency administrative regulations – 907 KAR 1:631E, Vision program reimbursement provisions and requirements; 907 KAR 1:038E, Hearing program coverage provisions and requirements; and 907 KAR 1:039E, Hearing program reimbursement provisions and requirements;] to eliminate an annual dollar limits on a benefit (eyeglasses); to establish program integrity provisions to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding. Currently, the administrative regulation contains annual dollar caps of $200 and $400 on eye glasses. These limits must be eliminated to comply with an Affordable Care Act mandate. The Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as “essential health benefits.” Medicaid benefits are within the scope of essential health benefits.

(2) This action must be taken on an emergency basis to comply with an Affordable Care Act mandate and to prevent a potential loss of state funds.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

_____

Steven L. Beshear
Governor

_____

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Emergency Administrative Regulation)

907 KAR 1:632E. Vision Program coverage provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d, 45 C.F.R. 147.126.

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Kentucky Medicaid program provisions and requirements regarding the coverage of vision services.

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(2) "Department" means the Department for Medicaid Servicers or its designee.

(3) “Enrollee” means a recipient who is enrolled with a managed care organization.

(4) “Federal financial participation” is defined by 42 C.F.R. 400.203.

(5) “Healthcare common procedure coding system” or “HCPCS” means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures or items.

(6) “Managed care organization” means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(7) “Medically necessary” or “medical necessity” means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(8) "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or KRS 326.040.

(9) “Optometrist” is defined by KRS 311.271.

(10) “Provider” is defined by KRS 205.8451(7).

(11) “Recipient” is defined by KRS 205.8451(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a vision service or item the service or item shall be:

1. Provided:

a. To a recipient; and

b. By a provider who is:

(i) Enrolled in the Medicaid program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid program pursuant to 907 KAR 1:671; and

(iii) Authorized by this administrative regulation to provide the given service or item;

2. Covered in according with this administrative regulation;

3. Medically necessary;

4. A service or item authorized within the scope of the provider's licensure; and

5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid program.

(2)(a) To be recognized as an authorized provider of visions services, an optometrist shall:

1. Be certified by the:

a. Kentucky Board of Optometric Examiners; or

b. Optometric examiner board in which the optometrist practices if the optometrist practices in a state other than Kentucky;

2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)1. To be recognized as an authorized provider of visions services, an in-state optician shall:

a. Hold a current license in Kentucky as an ophthalmic dispenser;

b. Comply with the requirements established in KRS Chapter 326;

c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of visions services, an out-of-state optician shall:

a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;

b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(3)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department for multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(4) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(5)(a) If a provider receives any duplicate or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(6) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Vision Service Coverage. (1) Vision service coverage shall be limited to a service listed with a CPT code on the Department for Medicaid Services Vision Program Fee Schedule.

(2) Vision service limits shall be as established on the Department for Medicaid Services Vision Program Fee Schedule.

Section 4. Coverage of Eyeglasses and Frames. (1) To be eligible for eyeglasses covered by the department, a recipient shall:

(a) Be under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21) years of age; and

(b) Have a diagnosed visual condition that:

1. Requires the use of eyeglasses;

2. Is within one (1) of the following categories:

a. Amblyopia;

b. Post surgical eye condition;

c. Diminished or subnormal vision; or

d. Other diagnosis which indicates the need for eyeglasses; and

3. Requires a prescription correction in the stronger lens no weaker than:

a. +0.50, 0.50 sphere+0.50, or 0.50 cylinder;

b. 0.50 diopter of vertical prism; or

c. A total of (two) 2 diopter of lateral prism.

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per twelve (12) consecutive month period unless:

1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive month period; or

2. The eyeglass prescription for the recipient is changed during the twelve (12) consecutive month period.

(b) If an event referenced in paragraph (a)1 or 2 occurs within the twelve (12) consecutive month period, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the twelve (12) consecutive month period.

(3) For the department to cover:

(a) A frame, the frame shall be:

1. First quality;

2. Free of defects; and

3. Have a warranty of at least one (1) year; or

(b) A lens, the lens shall be:

1. First quality;

2. Free of defects;

3. Meet the United States Food and Drug Administration's impact resistance standards; and

4. Polycarbonate and scratch coated.

(4) The dispensing of eyeglasses shall include:

(a) Single vision prescriptions;

(b) Bi-focal vision prescriptions;

(c) Multi-focal vision prescriptions;

(d) Services to frames; or

(e) Delivery of the completed eyeglasses which shall include:

1. Instructions in the use and care of the eyeglasses; and

2. Any adjustment, minor or otherwise, for a period of one (1) year.

(5) A provider shall be responsible, at no additional cost to the department or the recipient, for:

(a) An inaccurately filled prescription;

(b) Defective material; or

(c) An improperly fitted frame.

Section 5. Contact Lenses, Tint, and Plano Safety Glasses. (1) The department shall not reimburse for contact lenses substituted for eyeglasses unless:

(a) The corrected acuity in a recipient's stronger eye is twenty (20)/fifty (50) and shall be improved with the use of contact lenses;

(b) The visual prescription is of ± 8.00 diopter or greater; or

(c) The recipient's diagnosis is 4.00 diopter anisometropia.

(2) The department shall not reimburse for tint unless the prescription specifically indicates a diagnosis of photophobia.

(3) The department shall not reimburse for plano safety glasses unless the glasses are medically indicated for the recipient.

Section 6. Non-covered Services or Items. The department shall not reimburse for:

(1) Tinting if not medically necessary;

(2) Photochromics if not medically necessary;

(3) Anti-reflective coatings if not medically necessary;

(4) Other lens options which are not medically necessary;

(5) Low vision services;

(6) A press-on prism; or

(7) A service with a CPT code or item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 7. Required Provider Documentation. (1)(a) In accordance with 42 C.F.R. 431.17, a provider shall maintain medical records of a service provided to a recipient for the period of time currently required by the United States Health and Human Services Secretary unless the department requires a retention period, pursuant to 907 KAR 1:671, longer than the period required by the United States Health and Human Services Secretary.

(b) If, pursuant to 907 KAR 1:671, the department requires a medical record retention period longer than the period required by the United States Health and Human Services Secretary, the medical record retention period established in 907 KAR 1:671 shall be the minimum record retention period.

(c) A provider shall maintain medical records of a service provided to a recipient in accordance with:

1. 45 C.F.R. 164.316; and

2. 45 C.F.R. 164.306.

(2) A provider shall maintain the following documentation in a recipient's medical record:

(a) Any covered service or covered item provided to the recipient;

(b) For each covered service or covered item provided to the recipient:

1. A signature by the individual who provided the service or item signed on the date the service or item was provided;

2. The date that the service or item was provided; and

3. Demonstration that the covered service or covered item was provided to the recipient;

(c) The diagnostic condition necessitating the service or item; and

(d) The medical necessity as substantiated by an appropriate medical order.

Section 8. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature upon request.

Section 9. Federal Approval and Federal Financial Participation. The department’s coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services’ approval for the coverage.

Section 10. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 11. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", December 2013, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 1:632E

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:632E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes Medicaid Program coverage policies and requirements regarding vision services. Previously, vision coverage provisions were addressed in 907 KAR 1:038, Hearing Program coverage provisions and requirements, which also established hearing coverage provisions. The Department for Medicaid Services (DMS) is creating this administrative regulation to separate vision coverage provisions from hearing coverage provisions which will remain in 907 KAR 1:038; thus, this administrative regulation is being promulgated in conjunction with 907 KAR 1:038E. Additionally, DMS is promulgating 907 KAR 1:039E, Hearing Program reimbursement provisions and requirements as well as 907 KAR 1:631E, Vision Program reimbursement provisions and requirements in conjunction with this administrative regulation. Though this is a new administrative regulation it does contain amended provisions. The primary amendment is eliminating, from the Vision Program, an annual dollar limit on eyeglasses. Currently, DMS has an annual eyeglass dollar limit of $200 per year or $400 per year depending on the recipient's benefit plan; however, DMS is eliminating the dollar limit and establishing that DMS will reimburse for up to two (2) pairs of eyeglasses per twelve (12) consecutive month period [one (1) pair is covered with an additional pair allowed if the individual's glasses are broken or lost or the prescription changes]. Another critical amendment is establishing that DMS's coverage of Vision Program services is contingent upon receipt of federal approval and federal funding. Additional amendments include the elimination of a manual - Vision Program Manual – that DMS incorporated by reference 907 KAR 1:038 and inserting electronic signature requirements to enable providers to sign via electronic signatures. DMS is no longer incorporating the manual by reference into regulation but is incorporating the Department for Medicaid Services Vision Program Fee Schedule by reference into this administrative regulation. The fee schedule limits eye examinations to one (1) per recipient per year in contrast to the current limit of one (1) per recipient per provider per year. The administrative regulation also contains program integrity requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid Program coverage provisions and requirements regarding vision services. Eliminating, from the Vision Program, the $200 and $400 annual limits on eye glasses is necessary to comply with a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential

health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Program integrity provisions are necessary to enhance the integrity of the program and adopting the Vision Program Fee Schedule is necessary to give providers a user friendly document regarding covered services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid Program coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing Medicaid Program coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation but it establishes Medicaid Program coverage provisions and requirements regarding vision services that were previously established in another administrative regulation. Please see the response to question (1)(a) for more information..)

(b) The necessity of the amendment to this administrative regulation: Please see the response to question (1)(b).

(c) How the amendment conforms to the content of the authorizing statutes: Please see the response to question (1)(c).

(d) How the amendment will assist in the effective administration of the statutes: Please see the response to question (1)(d).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or “fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.

(4) Provide an analysis of how the entities identified in question (3) will be impacted

by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of the regulated entities other than to properly bill for services and adhere to program integrity requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who need eyeglasses may benefit from altering the annual cap of $200 or $400 to up to two (2) pair of eyeglasses per year (if they meet the qualifying circumstances – the first pair of eyeglasses is lost or broken or the prescription changes.]

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid $9,139 in claims to opticians and Medicaid managed care organizations paid $548,235 in claims to opticians. For the same period DMS paid $696,300 in claims to optometrists and Medicaid managed care organizations paid $19,096,123 in claims to optometrists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act, state matching funds, and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in funding will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly nor indirectly increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT services coverage – mandates coverage for individuals under twenty-one (21).

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 1:632E
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 U.S.C. 1396a(a)(33), 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. Vision services for Medicaid recipients are not mandated by Kentucky law; however, the Department for Medicaid Services is required by KRS 205.8453 to "institute other measures necessary or useful in controlling fraud and abuse."

   KRS 205.520(3) states: " . . . . it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1).

   42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if—
   (a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and
   (b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform."

   Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care.

   42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:
   ". . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services . . . ."

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:632E
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), and 45 C.F.R. 147.126.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS expects that the amendment will not generate revenue.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS expects that the amendment will not generate revenue.
   (c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. “fee-for-service” or “FFS” paid $9,139 in claims to opticians and Medicaid managed care organizations paid $548,235 in claims to opticians. For the same period DMS paid $696,300 in claims to optometrists and Medicaid managed care organizations paid $19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.
   (d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. “fee-for-service” or “FFS” paid $9,139 in claims to opticians and Medicaid managed care organizations paid $548,235 in claims to opticians. For the same period DMS paid $696,300 in claims to optometrists and Medicaid managed care organizations paid $19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): ____
Expenditures (+/-): ____

Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:632E

Summary of Material Incorporated by Reference

The “Department for Medicaid Services Vision Fee Schedule”, December 2013, is incorporated by reference. This four (4)-page document displays reimbursement for vision services.